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**TEXAS HEALTH CARE ASSOCIATION  
TESTIMONY REGARDING  
PROPOSED 2010 - 2011 MEDICAID RATES FOR NURSING FACILITIES  
August 3, 2009**

My name is Tom Plowman and I am the Director of Rate and Financial Analysis for the Texas Health Care Association (THCA). Founded in 1950, the THCA is the largest long term care association in Texas, representing a broad spectrum of long-term care providers and professionals offering long term, rehabilitative and specialized health care services. Member facilities, owned by both for-profit and non-profit entities, include nursing facilities, specialized rehabilitation facilities, and assisted living facilities. I am here today to testify on the FY 2010 – 2011 Medicaid rates for nursing facilities, as proposed by the Health and Human Services Commission (HHSC) ratesetting staff. To that end, I would like to thank the staff for providing us with the relevant information in a timely manner and for meeting with us to explain how the rates were calculated.

In respect to those calculations, they represent another example of how the chronic underfunding of the Medicaid program has forced HHSC to continually depart from its published ratesetting methodology. The original methodology assumed that rates would be cost based, with inflation assumptions used to project reported costs forward to set rates on a prospective basis. In the past decade, however, funding for this program has been bridled, and in some instances reduced, for budgetary reasons. Under this type of state fiscal environment, many of the assumptions built into the original cost based methodology lose their relevance and actually become detrimental in terms of setting rates in a logical, fair, and predictable manner. While we understand that addressing many of these issues would require rule changes, we would like to offer the following thoughts for you to consider as we move forward.

Standardization of the Case Mix Indices – Although there is merit to the practice of standardizing the case mix indices (CMI) under a cost based system, it becomes a disruptive influence on the rate if the system is no longer based upon costs. Subsequent “normalizing” the CMIs every rate setting cycle renders the system unpredictable and contravenes the true intent of a case mix system, that is, to match as closely as possible, allocation of resources to acuity levels. Continuing this practice will ultimately move the new RUGs system back towards the acuity spectrum of the TILE system that

was just abandoned. Further, the proposed reductions in certain RUG categories offer a disincentive to provide care at the highest acuity levels, which could ultimately lead to provision of care for these clients in much more costly hospital settings.

Proportional Allocation of Funding to Rate Components – This departure from the ratesetting methodology began when reimbursement was no longer cost based. This current practice is not a fair and equitable means to distribute funding if for no other reason than the Fixed Capital Use Fee methodology, with its built-in cap on reimbursement. This problem was exacerbated with the implementation of the RUGs system, when funding was distributed overwhelmingly to the resident care areas. As a result, the system is completely unpredictable and the rate components are totally out of balance. To counter this effect, we suggest that funding be applied to those components most out of balance until they come into line with the underfunded percentages of the other rate components and / or until the methodology once again is fully funded and cost based.

Fixed Capital Use Fee – We appreciate the recent efforts put forth by the agency in regard to the workgroup that was convened to restructure this rate component to help upgrade physical plants, and we were disappointed when funding was not provided with which to implement the plan. Nevertheless, a short term solution to allocating more resources to this component would be to remove the cap (“Alternative # 1”) and rebase the fee using the most recent tax appraised values per licensed bed (“Alternative # 2”).

Staffing Enhancement Considerations – The agency should look into basing case mix adjustments to the staffing enhancement system upon more current data than the 1999 database. Thorough analysis should be performed beforehand, however, to prevent major upheaval of the current system and to keep as much predictability as possible intact. Secondly, the agency should fund the staffing enhancement levels at the appropriate level of \$0.44 (per LVN-equivalent minute of staffing) instead of the arbitrarily reduced amount of \$0.39. Continually underfunding the “add-on” in this way inhibits providers’ ability to increase staff.....the primary goal of the staffing enhancement system. The \$3 - \$4 million in general revenue required should be obtainable within the current HHSC Enterprise appropriation levels.

Changes at the Federal Level - In 2005, the Centers for Medicare & Medicaid Services (CMS) initiated a national nursing home staff time measurement study referred to as the STRIVE (Staff Time and Resource Intensity Verification) Project. CMS states that data collected in this effort may be used to update payment systems for both Medicare and Medicaid programs. What is HHSC’s plan in this regard? What will the impact be on the Texas Medicaid program and Texas nursing facilities? Although there may be no answers to these questions presently, these are issues to be considered as the Texas RUGs system continues to evolve.

The TILE to RUGs Transition – Regardless of the best laid plans of the state and the fully cooperative efforts of the provider community, it is readily apparent that a system change of this magnitude in a state as large of Texas simply cannot be successfully transitioned in one year. The claims payment / forms processing system is still not functioning as it should, and we are almost a year into the program. When it is time for the OIG to perform RUG reviews, the forms and the data pulled from this first year will be highly suspect, and may ultimately lead to complicated appeals the volume of which has never occurred before. Staffing enhancement recoupments will run at an all time high for FY 2009; initial data collected from THCA members representing 229 facilities who are tracking their enhancement levels suggest \$8.5 million in recoupments for FY 2009. When projected to the entire industry the number approaches \$38 million. To assume that this type of upheaval will settle within one year, as the proposed rules eliminating the reinvestment feature suggest, is unrealistic. Many of these issues clearly fall outside the parameters of the ratesetting process, but they are also closely intertwined within this incredibly complex system. THCA and its resources stand ready to participate in every workgroup necessary to address these issues, but it is critical that the agency retreat from some of its aggressive timetables until such a time that evidence suggests that the transition truly has been completed.

On behalf of the Texas Health Care Association, I would like to thank you for the opportunity to submit these comments.